OFFICE OF THE INSPECTOR GENERAL FOR MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

Primary Inspection
Commonwealth Center for Children and Adolescents

James W. Stewart, III
Inspector General

Report #109-05

COMMONWEALTH CENTER FOR CHILDREN AND ADOLESCENTS
STAUNTON, VIRGINIA
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OIG Report #109-05

INTRODUCTION: The Office of the Inspector General (OIG) conducted a primary inspection at the Commonwealth Center for Children and Adolescents (CCCA) in Staunton, Virginia during December 16-17, 2004. The inspection focused on a review of the facility through the application of 19 quality statements grouped into 6 domains that include: facility management, access to services, service provision, discharge, environment of care, and quality and accountability. The quality statements were formulated through interviews completed by the OIG with a number of stakeholder groups. These groups included the mental health facility directors, consumers, Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) central office administrative staff, DMHMRSAS Office of Mental Health Services staff and directors of mental health services for community services boards (CSB). The quality statements and the information obtained by the OIG through observations, interviews and a review of documents are described in this report. The report is divided into sections that focus on each of the domains previously noted.

SOURCES OF INFORMATION: Interviews were conducted with 28 members of the staff including administrative, clinical and direct care staff. Interviews were also completed with 4 consumers. All of the consumers interviewed were over the age of fourteen. Documentation reviewed included, but was not limited to: 4 clinical records, selected policies and procedures, staff training curricula, facility quality management plan, and risk management reviews. A tour of the facility was conducted.

BACKGROUND: CCCA is the only facility operated by DMHMRSAS that is dedicated to the care and treatment of children and adolescents. This 48-bed facility has been in operation at its current site since 1996. On the day of the inspection, the facility had a census of 26 consumers. Referrals to the facility come from all forty of the community services boards across the Commonwealth.

Information provided by the facility indicated that the approved budget in FY 2004 was $7,621,362, with expenses for the same period of $7,619,240. The facility reported that the difference between the budget and the expenses was due to the receipt of federal grant funds, which were used for administrative and programming costs. The budget for FY 2005 is $7,865,243. This represents an increase in funding of $246,003 from the actual expenses of the previous fiscal year. The cost per bed day as reported by the facility is $1,019. This includes support provided by Western State Hospital.

MENTAL HEALTH FACILITY QUALITY STATEMENTS

Facility Management

1. The facility has a mission statement and identified organizational values that are understood by staff.

Interviews revealed that the facility has a mission statement and identified organizational values. All of the staff interviewed were able to identify the major components of the mission statement. Twenty-six of the 28 interviewed were able to demonstrate a good working knowledge of the organizational values. Two members of the administrative staff were unable to identify three organizational values.

The CCCA mission statement:

> *The mission of the Commonwealth Center for Children and Adolescents is to serve those children and adolescents admitted to the Center by providing psychiatric, diagnostic, evaluation and treatment services of the highest quality attainable at a reasonable cost to the Commonwealth and in coordination with the family, community services and the professional community. The Center's services are provided to Virginia's youth in an environment that promotes dignity and respect of children and adolescents toward the goal of improvement in their lives and development of their fullest potential.*

CCCA has eleven written value statements, a sampling of which include:

- We value providing the best quality services possible within the resources available to us.
- We value the privacy of the individual and believe that the Center's youth are worthy of our respect for their human dignity, potential and protection of their fundamental rights.
- We value the involvement of the children, their families and significant others in the entire treatment process.
- We value an environment within the Center of mutual respect and trust, clear communications and commitment to high professional and ethical standards.

2. The facility has a strategic plan.

Interviews revealed that the facility does not have a written strategic plan. Members of the facility leadership team reported that elements of the current strategic process include:

- Focusing on maximizing the flow-through of the census in order to return the consumers to their home communities as soon as possible;
- Increasing the quality of care by assuring that services provided are evidenced based; and
- Assuring that the facility maintains an integral role in the continuum of services to children and adolescents across the Commonwealth.

CCCA has over the past several years made a shift in services from the provision of longer term services more akin to a residential treatment facility to more intensive short-term treatment services. Interviews with administrative staff revealed that this change in services provision has been generated by several factors including the decrease in availability of acute care beds in the private sector, the identified needs of the community and the belief that children and adolescents, after being stabilized, are best served in their home community within their natural support systems.

3. The mission and strategic plan have been reviewed and are linked to the recently adopted DMHMRSAS Vision Statement.

Administrative staff indicated that the facility has not completed a formal review of its mission and strategic plan in conjunction with the DMHMRSAS vision statement. It was reported that the facility remains committed to providing services that are based on principles consistent with current child development theory by providing increased opportunities for each child to gain self-awareness and understanding, to increase self-management skills and to learn more effective communication strategies. Administrative staff stated that the facility's active involvement in the Special Population Workgroup currently reviewing and redefining needs and goals of service provision for children and adolescents is one way for CCCA to keep abreast of DMHMRSAS' objectives in serving this special population.

4. There are systems in place to monitor the effectiveness and efficiency of the facility.

Administrative staff reported that one of the methods used by the facility to determine the effectiveness of the services provided is to conduct consumer and family satisfaction surveys. Copies of the survey are distributed to families by social workers at the time of discharge. The data provided to the OIG from the facility for the 2nd and 3rd quarters of FY04 (October 2003- March 2004) indicated that 120 surveys were completed out of the 240 discharges that occurred during that timeframe. Overall, the returned survey results indicated a high degree of satisfaction with the services provided.

The facility monitors data in a number of the areas such as the use of seclusion and restraints, staff injuries, patient injuries and critical incidents, the number of readmissions within 30 days of discharge and incidents of peer-to-peer aggression. Interviews revealed that the data in each of these areas provides the facility with useful information for determining the effectiveness of its services and interventions.

Outcome measures have been established and are reviewed by the facility's leadership team and by the various disciplines to determine the effectiveness of the work completed. Examples of these measures include record reviews for both content and timeliness of the documentation, medication reviews to assure their proper usage, and individual case reviews to assure assessment and treatment strategies are individualized and timely.

Administrative staff reported that the utilization review process and management of the facility flow-through are primary mechanisms for measuring the efficiency of the facility.

5. There are systems in place to assure that there is a sufficient number of qualified staff.

Data provided by the facility indicated that CCCA has 137 approved full-time employee positions, of which 131.8 were filled at the time of the inspection. Of these positions, there were 64 direct care associate positions and 13 nursing positions.

CCCA staffing also includes the following numbers of clinical staff:

- 4 FT psychiatrists, including the medical director
- 5 FT psychologists, including the Director of Psychology
- 10 FT social workers, including the Director of Social Work
- 3 nurse manger positions, including the Director of Nursing
- 4 FT activities therapists
- 2 assistant program managers
- 1 Clinical Director

Direct care worker turnover has been a significant problem for this facility in the past. The facility has implemented a number of retention efforts such as paying a shift differential for 2nd shift and increasing opportunities for staff development. Interviews with administrative and direct care staff revealed that these efforts have been effective in reducing the amount of turnover. Issues related to safety and more competitive salaries in community-based services were cited as factors that continue to impact staff retention. The facility reported that the entry-level annual salary for RNs at the facility is $36,766 with the average salary for the last five RNs hires as $43,222. The entry-level annual salary for direct care associates is $18,026. The average salary for the last five DSAs hired was noted as $20,525. The higher salaries for recent hires were attributed to the competitive market.

Each staff member hired undergoes a background check and is prohibited from assuming sole responsibility for the consumers until the checks are completed and clearance is received. All staff participate in an orientation process with newly hired direct care staff completing 80 hours of classroom and "hands-on" instruction in areas such as child development, childhood trauma, psychiatric problems in children and adolescents, effective communications and behavior management strategies. Competency reviews are conducted by the appropriate supervisor to assure that staff understand and are able to demonstrate the ability to carry out assigned tasks. Annual reviews of key policies and procedures are conducted.

Staffing patterns and consumer activities on the units as observed by the OIG, during the day shift, on the first day of the inspection included the following:

Unit A: Nine staff members, including clinical and direct care staff, were on the unit. None of the direct care staff were reported on overtime. The census for this unit was reported as 6. There were no consumers on 1:1.

Unit B: When OIG staff visited this unit, most of the consumers were in the facility-based school program. There were 3 staff on the unit, none of whom were on overtime. The census for the unit was 7. Two consumers were on a 1:1 observational status. Those who remained on the unit were observed either playing with legos, video games or watching a movie.

Unit C: At the time of the OIG visit, this unit had 3 staff members. No one was working overtime. The census for the unit was 7. There were not any consumers on 1:1. At the time of the visit the children had returned from school and were having their snacks, playing games or were resting in their rooms. Staff were informed that these activities were customary during the change of shift that occurs between 3:00 pm to 3:30 pm.

Unit D: OIG staff observed 4 staff members on the unit. Interviews revealed that no one was working overtime. The census was 6. One consumer was on 1:1 observational status. The majority of children were in school. The consumer on the unit was interacting with staff and playing with toys and listening to music.

6. There are mechanisms for direct care staff and clinical staff to participate in decision-making and planning activities.

Administrative staff reported that since direct care staff comprises the largest percentage of the overall staffing their participation in decision- making and planning activities is vital to the functioning of the organization. This was reported as particularly true in the overall care provided to the consumers. It was reported that staff are encouraged to actively participate in the formation of the consumer's individualized treatment plan. Staff are provided with opportunities to serve on committees and performance improvement teams.

Interviews were conducted with 8 direct care workers. All stated that there are mechanisms for them to share their thoughts regarding the individualized care and treatment of consumers. This is particularly true during the treatment review process and during shift exchange. Direct care staff also reported that the patient advocate provides another avenue to make input.

Six of the 8 direct care staff who were interviewed said they had been provided opportunities to participate in facility-wide planning and decision making activities. Two staff members stated that they felt heard when asked to provide input or make suggestions. Three staff indicated that feedback can be provided about facility operations but it is not heard. The other staff member indicated that often times the administration will implement a new procedure without first seeking input from appropriate staff members resulting in staff making comments after the fact when the process is being

evaluated. The staff member went on to suggest that the facility was "getting squeezed into a medical model, which does not readily lend itself to an open dialogue about services or activities".
Clinical staff interviewed reported having a variety of mechanisms for participating in decision-making and planning activities such as participation on the leadership and clinical administrative review teams. Another example mentioned was through TOAD (Therapeutic Options, Analysis and Debriefing). This technique involves an open discussion with staff involved in a seclusion and/or restraint process to determine if other options might be tried with the consumer if similar situations present themselves. It was reported to be a "good working tool" for encouraging staff to think through an event in a non-judgmental setting for the benefit of the consumer.

7. Facility leadership has a plan for creating an environment of care that values employees and assures that treatment of consumers is consistent with organizational values.

Interviews with staff on all levels indicated that there are a number of ways in which the facility works to demonstrate to staff that they are valued. All of the direct care staff interviewed indicated that they felt valued on the unit level and 5 out of the 8 direct care staff members reported feeling valued by the administration. Among the ways cited for making staff feel valued were the added shift differential, small rewards for performance on the unit and for dealing with challenging patients, willingness to be flexible with schedules, efforts to make sure employees are well trained and understand the techniques they are expected to use, the provision of work shirts with the facility logo for staff, appreciation day, and the monetary bonus system for attendance and taking on added responsibility.

On the first day of the inspection, the facility was sponsoring a silent auction and Christmas party for the staff. Administrative staff had been on site the previous evening during the night shift to celebrate with the staff. A number of staff members voluntarily approached the OIG staff to state how appreciative they were of the party and the opportunity for staff to celebrate together.

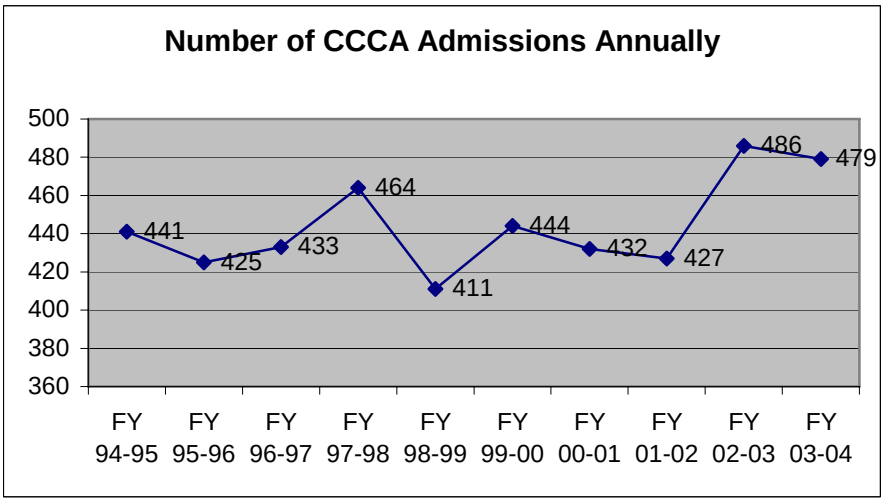
Those interviewed also indicated that the facility's clinical services plan links the overall philosophy of treatment with the organizational values to assure that there is consistency between the two. A review of the plan by the OIG confirmed this linkage.

Access

1. There are systems in place to assure that those admitted to the facility are appropriate.

CCCA is the only DMHMRSAS-operated program that serves both children and adolescents, ranging from the ages of four to eighteen years old. Southwestern Virginia Mental Health Institute in Marion has a 12–bed unit that serves adolescents between the ages of 14 and 18.

The following graph provides information regarding the number of admissions to the facility for the period of FY 1995 – FY 2004.



The number of admissions annually to CCCA has varied from a low of 411 to a high of 486 over the ten year period from FY1995 to FY2004. Comparing the number of admissions in FY1995 (441) to FY2004 (479) reveals an increase of 38 admissions or 8.6%.

CCCA has an admissions coordinator who handles admission referrals during the dayshift Monday through Friday. Social Workers are on-call to handle after-hours emergency admissions. As with all state-operated facilities, the prospective consumer must be assessed by a prescreener from the appropriate community services board prior to admission. The prescreener will determine whether the consumer meets the statutory criteria for admission to an acute care setting. In addition, the prescreener will assure that there are no less restrictive alternatives to hospitalization available prior to initiating the referral.

Another route by which consumers are admitted to this facility is through the juvenile court system. Children and adolescents admitted to the facility for court-ordered for evaluations. These 10-day evaluations are designed to provide a comprehensive assessment of the person's status and functioning, which assists the court in determining appropriate interventions and dispositions.

Data provided by the facility indicated that there were 499 admissions to the facility during the calendar year 2004. Of those, 280 were male and 219 were female. It was reported that there were 1,002 requests for admissions during the same time period.

The three primary reasons cited for admissions being denied were:

- The applicant had access to private insurance.
- The applicant did not meet acute hospitalization criteria

- There was bed space available in the community to divert or delay the admission.

The following graph shows the number of consumers admitted to the facility from the five health planning regions during FY2002, FY2003 and FY 2004.

Annual Admissions by Health Planning Region				
HPRs	FY 2002	FY2003	FY2004	Percentage of Total FY2004
I – Northwest VA	132	165	160	33.4%
II – Northern Virginia	68	92	88	18.4%
III – Southwest VA	75	84	69	14.4%
IV - Central VA	95	94	109	22.8%
V – Eastern VA	51	51	53	11.1%
Total Admissions	421	486	479	100%

In the most recent year, HPR I admitted 160 individuals to the facility which was 33.4% of the total number of admissions. One likely contributing factor is that CCCA is physically located in HPR I. HPR III and HPR V had the lowest utilization at 69 admissions (14.4%) and 53 admissions (11.1%) respectively. These two regions are most distant from the facility geographically.

Between FY2000 and FY2004, the number of children under six years of age who were admitted to the facility doubled from 5 to 10; the number of admissions for children age 6 to 13 years dropped 25% from 207 to 156; and the number of adolescents age 14 to 17 years increased 35% from 232 to 313.

	CCCA CONSUMER AGE AT THE TIME OF ADMISSION (FY 2000 – FY 2004)							
	5yrs 11 mos & under	**6 yrs-7y11m**	**8yrs - 9y11m**	**10 yrs-11y11m**	**12 yrs - 13y11m**	**14 yrs-15y11m**	**16 yrs - 17y11m**	**Total Admissions**
FY2000	5	17	39	63	88	106	126	444
FY2001	5	16	46	66	63	94	142	432
FY2002	0	17	38	36	84	109	137	421
FY2003	6	19	23	53	85	130	170	486
FY2004	10	16	21	41	78	143	170	479
% of FY2004 Total	2.1%	3.3%	4.4%	8.6%	16.3%	29.8%	35.5%	

2. The facility works collaboratively with CSB's to assure access to appropriate services when admissions to the facility are inappropriate or not possible due to census.

Interviews with administrative staff revealed that the facility works in partnership with the CSBs to assure that the admission is the least restrictive alternative for the applicant and the family. Consultation services are available to assist with placement if hospitalization is determined to be inappropriate.

The facility reported maintaining good working relationships with the CSBs. It was indicated that administrative staff are open to feedback from the community in developing ways to support their work in aiding children and families. Members of the facility have served an active role in the special populations workgroup that has made recommendations to the restructuring and reinvestment advisory group regarding current and future needs for children services in Virginia.

Service Provision

1. There are systems in place to assure that the consumer receives those services that are linked to his/her treatment needs and identified barriers to discharge.

Each person admitted to the facility undergoes as series of assessments by a number of disciplines. A nursing screening of both medical and psychiatric risk factors occurs within the first half-hour of the admission process. A complete physical examination and psychiatric evaluation are completed within the first 24-hours of admissions. The majority of assessments are to be conducted prior to the formal treatment planning session, which occurs within seven days of admission, since they become the basis for developing the individualized treatment plan. Interviews with clinical staff indicated that treatment objectives are prioritized with a focus on those objectives that are "barriers" to the person re-entering the community. Record reviews revealed that the treatment teams identify the barriers to discharge for each resident and develop interventions to address these barriers during hospitalization.

Each unit in the facility has a clinical director, who is responsible for developing and monitoring the individual's treatment plan. The clinical director is typically a licensed clinical psychologist. The treatment team provides input, on-going assessments and makes recommendations for service provision and discharge planning. The child, family and members of involved community agencies are considered members of the treatment team and are strongly encouraged to take active roles. Due to the considerable distances involved for some of the families and community representatives to travel, the facility works to assure their participation by using phone conferencing for treatment team meetings when needed.

Consumers participate in an accredited school program operated by the Staunton City School System. The school follows the same schedule as the local public school system.

Educational services are individualized and become a part of the overall treatment process.

Active treatment programming is provided during the early evening hours and on weekends. Members of the activities therapy department oversee these services that include a number of group activities such as substance abuse services, anger management and leisure skills.

2. There are processes in place that support evidence-based practices.

Interviews with administrative staff indicated that the overall model for service delivery is based on evidenced-based practices consistent with current child development theory, which provides increased opportunities for each child to gain self-awareness and experience positive social interactions. The facility has developed interventions based on a number of theoretical constructs that utilize a collaborative approach in working with the children and their families, fosters experiential techniques such as behavioral self-regulation, and creates a supportive environment. Medication usage is based on available practice guidelines for children.

3. The facility assures that service provision is grounded in the principles of recovery, self-determination and empowerment.

As noted above interviews with clinical and administrative staff reported that recovery, self determination and empowerment principles are used in the context of current child development theory and current treatment strategies regarding psychiatric problems in children and adolescents.

Interviews revealed that these approaches are stressed in new staff training. Some of the areas in which staff receives instruction are as follows: understanding depression and suicide in adolescents, therapeutic communications, substance abuse issues in children and adolescents and how to effectively work with families.

One goal established by the facility for January through August 2005 is to build a trauma sensitive program. Additional training activities have been scheduled to assist staff in understanding the impact of traumatic stress on children.

4. There are systems in place to measure the perceptions of consumers, families, direct care staff, clinical staff and administrative staff regarding the quality of the provision of care and services.

There are formal and informal mechanisms at CCCA for measuring the perceptions of the consumers, their families and staff regarding the quality of the care and services provided. The facility uses a parent/caregiver satisfaction survey to assess how parents and other caregivers perceive the quality of services provided.

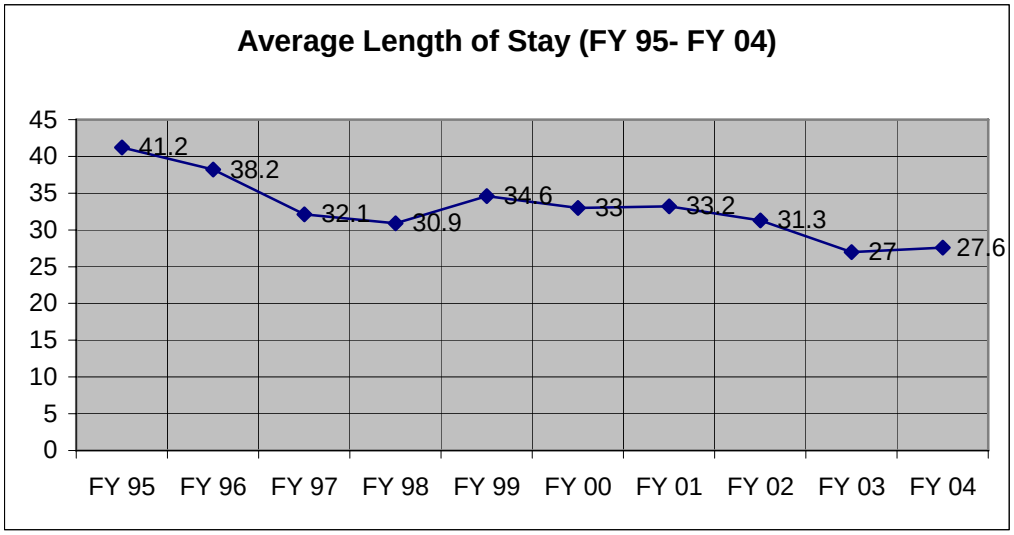
Staff perceptions are measured in supervisory meetings and team meetings. The facility conducted a formal staff satisfaction survey two years ago, which resulted in some organizational changes. The majority (6 of 8) of direct care staff interviewed indicated that the facility director has an open door policy and that there are opportunities for them to provide feedback regarding the quality of services provided.

Discharge

1. There are systems in place for effective utilization review and management.

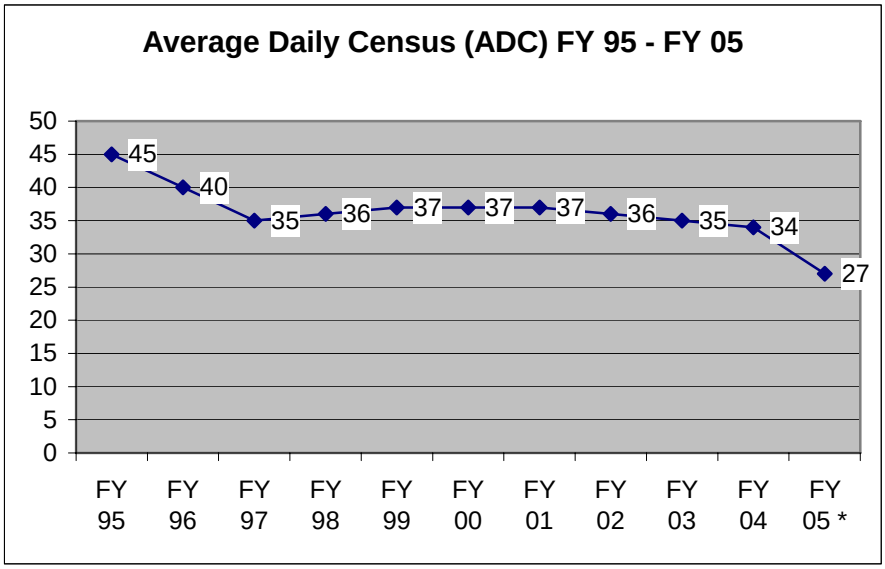
Utilization review (UR) and management for the facility occurs both within the context of the Clinical Review Committee and the treatment team. Since the facility has been focusing on providing more acute care services, increased emphasis has been placed on the on-going review and tracking of length of stay data.

The following chart depicts the average length of stay (ALOS) for consumers at CCCA over the past 10 years. During this period, the ALOS has decreased 33% from 41.2 days (FY 1995) to 27.6 days (FY 2003).



Utilization review within the facility focuses on three areas. The areas include the management of admissions, discharges and each consumer's course of treatment. Interviews with administrative staff indicated that UR data is compared with national norms for length of stay for the identified diagnosis of a consumer. On the first day after the established norm has been reached, there is a review of the case to determine the barriers to discharge and to review the clinical justification for continued hospitalization. It was reported that this approach keeps the treatment team focused on addressing the barriers so that community placement is not unnecessarily delayed. CCCA has a nursing UR coordinator whose primary responsibilities include providing consistent contact with insurance carriers and Medicaid regarding justifications for continued hospitalization and other coverage issues, attending treatment team meetings to stay informed of discharge planning and barriers, and maintaining data regarding continued stays.

The annual average daily census at CCCA dropped 24% from FY 1995 (ADC 45) to FY 2004 (ADC 34). During the first nine months of the current year, FY2005, the ADC has been significantly lower at 27. Averaging the ADC from FY 2001 through the first nine months of FY 2005 reveals an average five-year ADC of 33.8. With a facility bed capacity of 48 beds, the average daily census over the past years has been 70.4% of capacity.



* First nine months of FY 05.

Based on data provided by the facility, the number of days in which the census exceeded 75% of the 48 bed capacity has dropped dramatically over the past 3 years from 43.8% in FY 2003 to 9.15% in the first nine months of FY 2005.

Census / % Capacity	2003 / % of Days	2004 / % of Days	2005 / % of Days
0 to 12 / 25%	0 days	0 days	0 days
13 to 24 / 50%	11 days (3%)	26 days (7.1%)	107 days (39%)
25 to 36 / 75%	194 days (53.2%)	238 days (65%)	142 days (51,8%)
37 to 48 / 100%	160 days (43.8%)	102 days (27.9%)	25 days (9.1%)
	365 total days	366 total days	274 total days

2. There are systems in place to assure that effective communication occurs between the patient, facility and community liaisons regarding discharge readiness in order to assure a smooth transition of the consumer into the community and to prevent re-hospitalization.

Social workers serve as the primary point of contact between the facility, the consumers, family and the community. Family members and community liaisons are encouraged to participate in regularly scheduled treatment planning meetings during which discharge readiness and plans are explored. The facility facilitates this contact through the use of phone conferencing. It is the primary responsibility of the facility in partnership with the

consumer and the families to determine the needs of the consumer upon discharge. This information is communicated to the community liaisons whose responsibility it is to facilitate arrangements for service provision, including establishing appointments, housing and other identified service needs. Social workers also serve as consultants to the community regarding placement options.

All consumers and their families are provided information regarding emergency contacts at the appropriate community services board in the event that a crisis is experienced prior to the first scheduled appointment with the community treatment provider. This information was found in all of the discharge instructions reviewed. Staff stated that effective discharge planning and established community linkages are the best mechanisms for preventing re-hospitalization. On-going communication and coordination prior to discharge serves to create the most optimal opportunities for positive outcome. Throughout the discharge preparation process the facility works to obtain feedback and deal with concerns before the discharge actually occurs.

Quality of the Environment

1. The physical environment is suitable to meet the individualized residential and treatment needs of the consumers and is well maintained.

CCCA operates one unified treatment program that is divided into four treatment units. Placements on the units occur according to the consumer's age and developmental level. Two units (C and D) serve primarily adolescents while the remaining two units (A and B) typically serve children. All units are co-ed, with a mix of consumer functioning levels. The nursing station separates male and female bedroom areas.

Observations were made on all four residential units during the two-day inspection. Four consumers over the age of fourteen were interviewed. In addition, the OIG interviewed 8 direct care staff members including both direct care associates and nursing staff.

Overall the facility was clean and well maintained. All of the units were appropriately and safely decorated for the holidays. On the younger children's units, it was observed that the consumer bedrooms were neat. Staff shared with OIG staff that prizes are given for the best looking room on the unit as an incentive. All units have rooms designated for activities. The common areas were adequately furnished to address the needs of the consumers.

A holiday party for the consumers was scheduled during the second day of the inspection. The consumers were very excited about the events including gifts, refreshments and activities. Members of DMHMRSAS Central Office Division of Architecture and Engineering conduct fundraisers during the year in order to sponsor this event. Central Office staff traveled from Richmond to man the various stations and activities.

Interviews with the consumers revealed that 3 out of the 4 had been at the facility multiple times so they were able to provide information based on several experiences.

Three out of the 4 interviewed indicated that they did not like the food at the facility. The one person that did like the food did not feel that consumers were provided with enough food. Consumers have access to snacks brought from home and provided by the facility.

Those interviewed offered the following as the "most helpful to them during their stay": the 2nd shift staff and the doctors availability to address their issues, recreational activities such as lifting weights, the groups, staff giving patients some control, and staff working to help keep the patients busy.

Three out of the 4 consumers interviewed included the following when asked what was "least helpful" to them: the 30 minute time period after school when there is not time to initiate anything before groups start but too much time just to hang-out, other patients who act "very annoying" and some staff who constantly contradict themselves making it difficult to know how to follow the rules.

Operations moved into the current setting in 1996, making CCCA the newest facility in the overall facility system. No capital improvement projects are slated for this facility at this time.

2. There are systems in place to assure that the environment of care is safe and consumers are protected.

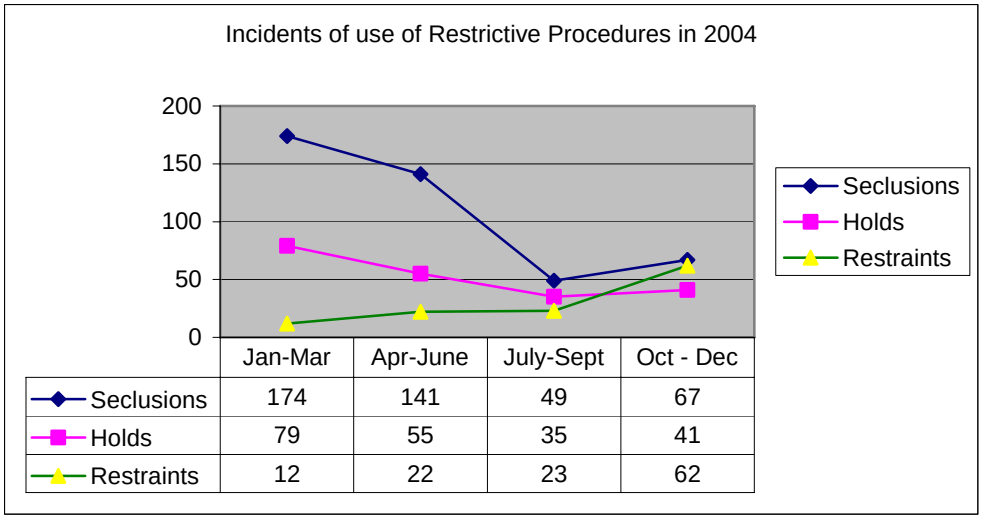
CCCA has a number of mechanisms in place to assure that the consumers at the facility are protected and safe. During orientation, new staff receives training in areas such as human rights, the reporting of abuse and neglect, and intervention strategies through an introduction to Therapeutic Options for Virginia (TOVA). In addition, the facility has a risk management program. The program includes the work of the risk manager and various committees designed to monitor patient specific and overall environmental safety concerns. The risk manager tracks data in a number of areas such as patient injuries, falls, patient related staff injuries and incidents of seclusion and restraint usage.

Interviews with staff on all levels indicated that one of the priorities of the facility is to assure the safety of the consumers. Direct care staff, however, reported that they do not feel that the safety of the staff is a high enough concern for the administration. Information provided by the facility indicated that there were 153 staff injuries reported during the calendar year 2004. Of this total, 133 were consumer related injuries.

The direct care staff members interviewed indicated that safety is measured in a number of ways. They identified the following as some of the safety measures established: assuring that the consumers are free from abuse and neglect, having adequate staff to address the treatment and supervision needs of the children, being provided with adequate training to successfully complete their job expectations, and conducting ongoing preventative and environmental safety checks such as fire drills, door security checks, and infection control inspections.

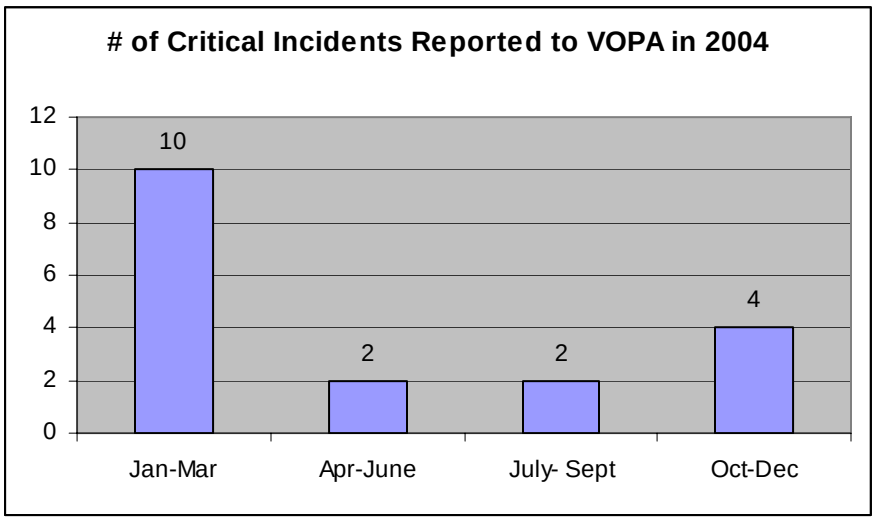
Of the four consumers interviewed, one indicated feeling safe within the environment. The other consumers stated that they feel safe at least 50% of the time. It is the behaviors of others that causes them to feel less confident about the facility's ability to assure their safety.

Information provided by the facility indicated that there were 431 incidents of seclusion, 210 incidents of physical holds and 119 incidents of mechanical restraint during calendar year 2004.

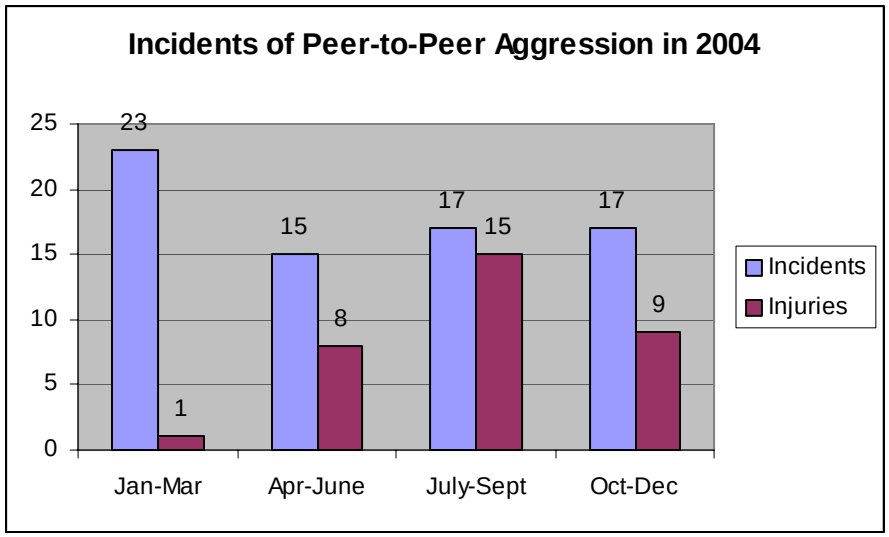


	Jan-Mar	Apr-June	July-Sept	Oct - Dec
Seclusions	174	141	49	67
Holds	79	55	35	41
Restraints	12	22	23	62

Eighteen critical incidents were reported to the Virginia Office for Protective and Advocacy. These incidents involved injuries to the consumers that required medical intervention by a physician or physician extender.



Data from the facility indicated that there were 72 incidents of peer-to-peer aggression during calendar year 2004. Of these, 33 incidents resulted in an injury to one or both of the consumers.



The facility investigated 11 allegations of abuse and neglect during calendar year 2004. All of the allegations were unfounded. There were four informal consumer complaints and no formal ones raised during the same time period.

Two consumer concerns came to the attention of OIG staff during the tour of the facility. (1) A consumer reported that he believed the procedure for getting students up for the day needed to take into account the differences in sleep patterns and wake-up needs of the consumers. (2) OIG staff witnessed a staff-to-consumer interaction regarding the consumer's dissatisfaction with the fact that vegetarian meals were not being provided as requested.

Quality And Accountability

1. There are systems in place to assure that the services provided from the time of admission to discharge are quality services.

CCCA has a quality management plan that states that quality management is "data-driven and has as its goal the improvement of clinical processes, mental health and physical outcomes for the children served. The program promotes the use of total quality management/continuous quality improvement constructs to enhance system effectiveness and client outcomes". Quality management activities are conducted at the departmental level, within the treatment teams, through the monitoring of human rights complaints, and through the risk management process. Among the quality management initiatives are the reduction in use of seclusion and restraint and utilization review and management of the facility census.

2. The facility has an accurate understanding of all of the stakeholders' perceptions regarding the services provided by the facility.

Satisfaction surveys are completed with the consumers and their families. On-going interactions with community providers and representatives from the community services boards allow for open dialogue regarding services and their working relationships.

Recommendations

The OIG has the following recommendation regarding the Commonwealth Center for Children and Adolescents as a result of this inspection. Based on the inspections of all 9 mental health hospitals and mental health institutes, a systemic review report will be issued in the near future that includes additional recommendations for all mental health facilities.

Finding #1:

Over the past several years, there have been significant changes in the facility's utilization patterns:

- The number of admissions annually increased 8.6% over 10 years from 441 (FY 95) to 479 (FY 04).
- The average length of stay (ALOS) decreased 33% over 10 years from 41.2 (FY 95) to 27.6 (FY 04).
- In 2004, the facility was able to prevent state hospitalization of 50% of the requests for admission (503 of 1002 requests) because applicant's had private insurance, applicants did not meet acute hospitalization criteria, or bed space could be located in the community.

As a result:

- The annual average daily census (ADC) dropped 24.4% over 10 years from 45 (FY 95) to 34 (FY 04).
- The ADC dropped 27% over the past 5 years from 37 (FY 01) to 27 (first 9 months of FY 05).
- With an average ADC of 33.8 over the past 5 years, the facility has operated at 70.4% of it's 48 bed capacity from FY 01 through the first nine months of FY 05.
- The number of days in which the census exceeded 75% of capacity dropped from 43.8% in FY 03 to 9.15% in the first nine months of FY 05.
- The current staffing ratios when calculated against the ADC of 33.8 over the past 5 years reveal the following:

	Current Complement	Staff to Consumer
Psychiatrist	4	1 to 8.5
Psychologist	5	1 to 6.76
Social Worker	10	1 to 3.38
Activity Therapist	4	1 to 8.5
Nurse Manager	3	1 to 11.4

- The cost per bed day as reported by the facility is $1,019. This is the highest daily cost of all 16 facilities operated directly by DMHMRSAS.

Two of the major factors that have enabled this significant decrease in the utilization of CCCA include effective diversion to community alternatives and successful utilization management by the facility.

Recommendation #1: It is recommended that DMHMRSAS and CCCA conduct a study with the involvement of a broad range of stakeholders to determine:

- The appropriate capacity for CCCA in order to serve the needs of the most seriously emotionally disturbed children and adolescents in the Commonwealth who cannot be served in less restrictive settings.
- The appropriate staffing complement to support this capacity.
- The financial resources required to operate the facility at this capacity
- What portion, if any, of the resources currently deployed to CCCA could be more effectively utilized to address the needs of seriously emotionally disturbed children and adolescents with the goal of providing services closer to home in less restrictive and less costly settings.

DMHMRSAS Response: The Department is aware of the difficult position that CCCA is in with regard to cost effective service and being the only freestanding treatment facility for children and adolescents and the only state facility for children under the age of twelve. The Department and CCCA will work together with stakeholders to discuss the appropriate size, staffing, resources and function of CCCA as a portion of restructuring and under the broader legislative mandate regarding the study of an integrated system for services for seriously emotionally disturbed youth under House Bill 330-H. I hope that you will be willing to be part of the discussion of the future of CCCA as we begin to explore its niche in the broader service continuum.